FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037655

Facility Name: FAIRVIEW NURSING PLAZA, INC.

Address: 321 ARNOLD AVE (Number) ROCKFORD (City) 61108 (Zip Code)

County: WINNEBAGO

Telephone Number: 815-397-5531 **Fax #** 815-397-7629

IDPA ID Number: 36-3782675-001

Date of Initial License for Current Owners: 1991

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) CARY BUXBAUM, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3	114	Intermediate (ICF)	114	41,724	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	213	TOTALS	213	77,958	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,377	816	1,091	20,284	8
9	SNF/PED					9
10	ICF	42,879	1,904	419	45,202	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,255	2,720	1,510	65,485	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.00%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/1991

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/1991 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 921

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	179,274	23,961	35,790	239,025		239,025	(19,850)	219,175			1
2	Food Purchase		271,652		271,652	(16,653)	254,999	(113)	254,886			2
3	Housekeeping	178,209	21,299	0	199,508		199,508	630	200,138			3
4	Laundry	73,403	7,530	0	80,933	0	80,933	0	80,933			4
5	Heat and Other Utilities			123,864	123,864		123,864	2,227	126,091			5
6	Maintenance	43,275	0	95,059	138,334		138,334	(18,901)	119,433			6
7	Other (specify):*	0	0	12,844	12,844		12,844	3,196	16,040			7
8	**TOTAL General Services**	474,161	324,442	267,557	1,066,160	(16,653)	1,049,507	(32,811)	1,016,696			8
	B. Health Care and Programs											
9	Medical Director	0		7,200	7,200		7,200	0	7,200			9
10	Nursing and Medical Records	1,361,004	106,645	678,198	2,145,847		2,145,847	(35,479)	2,110,368			10
10a	Therapy	37,438	0	8,008	45,446		45,446	0	45,446			10a
11	Activities	90,970	12,568	2,174	105,712		105,712	0	105,712			11
12	Social Services	145,562	0	4,738	150,300		150,300	0	150,300			12
13	Nurse Aide Training	0	0	0	0		0	0	0			13
14	Program Transportation	0	0	556	556		556	0	556			14
15	Other (specify):*	0	0	0	0		0	3,112	3,112			15
16	**TOTAL Health Care and Programs**	1,634,974	119,213	700,874	2,455,061	0	2,455,061	(32,367)	2,422,694			16
	C. General Administration											
17	Administrative	131,300	0	79,056	210,356		210,356	36,188	246,544			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			167,627	167,627	0	167,627	(92,419)	75,208			19
20	Dues, Fees, Subscriptions & Promotions			36,537	36,537		36,537	(4,398)	32,139			20
21	Clerical & General Office Expenses	80,571	23,659	111,486	215,716		215,716	(16,488)	199,228			21
22	Employee Benefits & Payroll Taxes			257,957	257,957	16,653	274,610	0	274,610			22
23	Inservice Training & Education			0	0		0	0	0			23
24	Travel and Seminar			2,439	2,439		2,439	758	3,197			24
25	Other Admin. Staff Transportation		0	1,855	1,855		1,855	3,197	5,052			25
26	Insurance-Prop.Liab.Malpractice			63,196	63,196		63,196	1,008	64,204			26
27	Other (specify):*	0	0	0	0		0	24,506	24,506			27
28	**TOTAL General Administration**	211,871	23,659	720,153	955,683	16,653	972,336	(47,648)	924,688			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,321,006	467,314	1,688,584	4,476,904	0	4,476,904	(112,826)	4,364,078			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

FAIRVIEW NURSING PLAZA, INC.
0037655
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	16,653	
2	FOOD		16,653

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. #0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			59,852	59,852		59,852	1,433	61,285			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			56,553	56,553		56,553	3,690	60,243			32
33	Real Estate Taxes			101,585	101,585	0	101,585	4,533	106,118			33
34	Rent-Facility & Grounds			942,238	942,238		942,238	0	942,238			34
35	Rent-Equipment & Vehicles			9,761	9,761		9,761	9,315	19,076			35
36	Other (specify):*			0	0		0	0	0			36
37	**TOTAL Ownership**			1,169,989	1,169,989	0	1,169,989	18,971	1,188,960			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	0	0	0	0		0	0	0			38
39	Ancillary Service Centers	0	39,285	15,210	54,495		54,495	(1,093)	53,402			39
40	Barber and Beauty Shops	0	0	0	0		0	0	0			40
41	Coffee and Gift Shops	0	0	0	0		0	0	0			41
42	Provider Participation Fee	0	0	116,938	116,938		116,938	0	116,938			42
43	Other (specify):*	0	0	0	0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	39,285	132,148	171,433	0	171,433	(1,093)	170,340			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,321,006	506,599	2,990,721	5,818,326	0	5,818,326	(94,948)	5,723,378			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,903)	30		9
10	Interest and Other Investment Income	(631)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(113)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(54,492)	21		18
19	Entertainment				19
20	Contributions	(1,053)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,038)	21		24
25	Fund Raising, Advertising and Promotional	(3,993)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(251)	20		28
29	Other-Attach Schedule	(14,900)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (96,374)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,426		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,426		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (94,948)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

FAIRVIEW NURSING PLAZA, INC.

ID# 0037655

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	C.O.P.E. Contribution	(277)	20	2
3	Trust Fees	(260)	20	3
4	Veterans' Expense	(8,469)	10	4
5	Capitalized Repair & Maintenance	(5,894)	6	5
6				6
7				7
8				8
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89				89
90	**Total**	(14,900)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(22,500)			2,650				(19,850)	1
2	Food Purchase	(113)											(113)	2
3	Housekeeping			630									630	3
4	Laundry													4
5	Heat and Other Utilities			851	1,376								2,227	5
6	Maintenance	(5,894)		525	(12,693)	(839)							(18,901)	6
7	Other (specify):*				738	2,458							3,196	7
8	**TOTAL General Services**	(6,007)		2,006	(10,579)	(20,881)			2,650				(32,811)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(8,469)			(23,792)				(3,218)				(35,479)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,112								3,112	15
16	**TOTAL Health Care and Programs**	(8,469)			(20,680)				(3,218)				(32,367)	16
	C. General Administration													
17	Administrative			14,721	(67,403)	84,700		4,170					36,188	17
18	Directors Fees													18
19	Professional Services			(89,010)	(15,000)	11,573		18					(92,419)	19
20	Fees, Subscriptions & Promotions	(5,834)		379	1,045			12					(4,398)	20
21	Clerical & General Office Expenses	(68,530)		48,882	3,134			26					(16,488)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			192	566								758	24
25	Other Admin. Staff Transportation			669	2,528								3,197	25
26	Insurance-Prop.Liab.Malpractice			429	557			22					1,008	26
27	Other (specify):*			7,680	4,663	11,669		494					24,506	27
28	**TOTAL General Administration**	(74,364)		(16,058)	(69,910)	107,942		4,742					(47,648)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(88,840)		(14,052)	(101,169)	87,061		4,742	(568)				(112,826)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(6,903)		3,137	5,199								1,433	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(631)		1,224	3,080			17					3,690	32
33	Real Estate Taxes			1,584	2,949								4,533	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles			2,708	6,295			312					9,315	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(7,534)		8,653	17,523			329					18,971	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(1,093)				(1,093)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**								(1,093)				(1,093)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(96,374)		(5,399)	(83,646)	87,061		5,071	(1,661)				(94,948)	45

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 630	$ 630	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	851	851	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	525	525	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	14,721	14,721	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,958	1,958	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	379	379	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	48,882	48,882	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	192	192	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	669	669	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	429	429	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	7,680	7,680	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	3,137	3,137	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	1,224	1,224	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,584	1,584	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,708	2,708	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	90,968	PREFERRED BOOKKEEPING	100.00%		(90,968)	32
33	V	19	COMPUTER	5,112	PREFERRED BOOKKEEPING	100.00%	5,112		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 96,080			$ 90,681	$ * (5,399)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,376	$ 1,376	15
16	V	6	REPAIRS AND MAINT.	19,176	S.I.R. MANAGEMENT, INC.	100.00%	6,483	(12,693)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	738	738	17
18	V	10	NURSING	42,180	S.I.R. MANAGEMENT, INC.	100.00%	18,388	(23,792)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,112	3,112	19
20	V	17	ADMINISTRATIVE	74,736	S.I.R. MANAGEMENT, INC.	100.00%	7,333	(67,403)	20
21	V	19	PROFESSIONAL FEES	17,256	S.I.R. MANAGEMENT, INC.	100.00%	2,256	(15,000)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,045	1,045	22
23	V	21	CLERICAL & GENERAL	21,732	S.I.R. MANAGEMENT, INC.	100.00%	24,866	3,134	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	566	566	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,528	2,528	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	557	557	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,663	4,663	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	5,199	5,199	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,080	3,080	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	2,949	2,949	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,295	6,295	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 175,080			$ 91,434	$ * (83,646)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 21,732	S.I.R. MANAGEMENT, INC.	100.00%	$ 5,309	$ (16,423)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	893	893	16
17	V	17	ADMIN./LEGAL SALARIES	0	S.I.R. MANAGEMENT, INC.	100.00%	84,700	84,700	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	11,573	11,573	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	11,669	11,669	19
20	V								20
21	V								21
22	V	10A	SPECIAL REHAB	0	S.I.R. MANAGEMENT, INC.	100.00%	0		22
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	0		23
24	V								24
25	V								25
26	V	6	REPAIRS AND MAINT.	2,760	S.I.R. MANAGEMENT, INC.	100.00%	1,921	(839)	26
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	334	334	27
28	V								28
29	V								29
30	V	1	DIETICIAN SALARIES	13,200	S.I.R. MANAGEMENT, INC.	100.00%	7,123	(6,077)	30
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,231	1,231	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 37,692			$ 124,753	$ * 87,061	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 47,446	$ 47,446	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	47,446	CCS EMPLOYEE BENEFIT GROUP	100.00%		(47,446)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 47,446			$ 47,446	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 18	$ 18	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	12	12	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	26	26	17
18	V	26	INSURANCE		ECM OWNERS COUNCIL	100.00%	22	22	18
19	V	32	INTEREST		ECM OWNERS COUNCIL	100.00%	17	17	19
20	V	35	VEHICLE RENTAL		ECM OWNERS COUNCIL	100.00%	312	312	20
21	V	17	MANAGEMENT FEES	4,320	ECM OWNERS COUNCIL	100.00%		(4,320)	21
22	V								22
23	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	8,490	8,490	23
24	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	494	494	24
25	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%	0		25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,320			$ 9,391	$ * 5,071	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	ENTERAL EQUIPMENT	$ 1,305	PARAMOUNT HEALTH CARE SYSTEMS	100.00%	$ 212	$ (1,093)	15
16	V	10	ENTERAL EQUIPMENT	3,442	PARAMOUNT HEALTH CARE SYSTEMS	100.00%	224	(3,218)	16
17	V	1	NUTRITIONAL SUPPLEMENTS		PARAMOUNT HEALTH CARE SYSTEMS	100.00%	2,650	2,650	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,747			$ 3,086	$ * (1,661)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Stockholder	Administrative	4.86%	See Attached	0.64	.0888%	Alloc Salary	$ 6,817	17-7	1
2	Mike Giannini	Stockholder	Administrative	13.89%	See Attached	4.07	8.14%	Alloc Salary	24,488	17-7	2
3	Louise Bergthold	Stockholder	Administrative	2.63%	See Attached	5.6	10.18%	Alloc Salary	17,319	17-7	3
4	Tom Winter	Stockholder	Administrative	.877%	See Attached	6.21	10.35%	Alloc Salary	14,721	17-7	4
5	Bryan Barrish	Stockholder	Administrative	27.78%	See Attached	4.58	9.16%	Alloc Salary	26,770	17-7	5
6	Arturo Rominiquit	Relative	Courier	0%	See Attached	4.14	10.35%	Alloc Salary	2,264	17-7	6
7	Nenita Guzman	Relative	Dietary	0%	See Attached	5.6	10.18%	Alloc Salary	5,309	17-7	7
8	Mark Solomon	Stockholder	Administrator	6.58%	None	40	100%	Salary	81,779	17-1	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 179,467		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	878,492	11	$ 6,088	$	90,968	$ 630	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	878,492	11	8,220		90,968	851	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	878,492	11	5,069		90,968	525	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	878,492	11	142,165	142,165	90,968	14,721	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	878,492	11	18,910		90,968	1,958	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	878,492	11	3,657		90,968	379	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	878,492	11	472,061	403,426	90,968	48,882	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	878,492	11	1,858		90,968	192	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	878,492	11	6,465		90,968	669	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	878,492	11	4,146		90,968	429	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	878,492	11	74,163		90,968	7,680	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	878,492	11	30,298		90,968	3,137	12
13	32	INTEREST	BOOK./ACCNT.INCOME	878,492	11	11,823		90,968	1,224	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	878,492	11	15,297		90,968	1,584	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	878,492	11	26,147		90,968	2,708	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						5,112	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 826,367	$ 545,591		$ 90,681	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	642,911	10	$ 13,508	$	65,485	$ 1,376	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	642,911	10	63,644	42,834	65,485	6,483	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	642,911	10	7,250		65,485	738	3
4	10	NURSING	PATIENT DAYS	642,911	10	180,529	180,529	65,485	18,388	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	642,911	10	30,553		65,485	3,112	5
6	17	ADMINISTRATIVE	PATIENT DAYS	642,911	10	71,994	71,994	65,485	7,333	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	642,911	10	22,153		65,485	2,256	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	642,911	10	10,256		65,485	1,045	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	642,911	10	244,124	177,193	65,485	24,866	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	642,911	10	5,556		65,485	566	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	642,911	10	24,821		65,485	2,528	11
12	26	INSURANCE	PATIENT DAYS	642,911	10	5,468		65,485	557	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	642,911	10	45,778		65,485	4,663	13
14	30	DEPRECIATION	PATIENT DAYS	642,911	10	51,045		65,485	5,199	14
15	32	INTEREST	PATIENT DAYS	642,911	10	30,234		65,485	3,080	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	642,911	10	28,948		65,485	2,949	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	642,911	10	61,803		65,485	6,295	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 897,664	$ 472,550		$ 91,434	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	642,911	10	$ 52,122	$ 52,122	65,485	$ 5,309	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	642,911	10	8,770		65,485	893	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	642,911	10	831,558	831,558	65,485	84,700	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	642,911	10	113,620		65,485	11,573	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	642,911	10	$ 114,558	$	65,485	$ 11,669	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	56,277	56,277	0	0	8
9	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	$ 9,470	$	0	$ 0	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	237,604	10	165,366	165,366	2,760	1,921	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	237,604	10	$ 28,790	$	2,760	$ 334	13
14										14
15										15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	67,672	67,672	13,200	7,123	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	11,698		13,200	1,231	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,459,901	$ 1,172,995		$ 124,753	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 47,446	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 47,446	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 676-2026
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	96,000	9	$ 400	$	4,320	$ 18	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	96,000	9	264		4,320	12	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	96,000	9	579		4,320	26	3
4	26	INSURANCE	ECMOC MGMNT FEE INC.	96,000	9	496		4,320	22	4
5	32	INTEREST	ECMOC MGMNT FEE INC.	96,000	9	374		4,320	17	5
6	35	VEHICLE RENTAL	ECMOC MGMNT FEE INC.	96,000	9	6,931		4,320	312	6
7										7
8										8
9	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	39	9	81,858	81,858	4	8,490	9
10	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	39	9	4,762		4	494	10
11	17	ADMIN. SALARY	DIRECT ALLOCATION						0	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 95,664	$ 81,858		$ 9,391	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PARAMOUNT HEALTH CARE SYSTEMS
Street Address: 6300 OAKTON
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847)470-4700
Fax Number: (847)470-4718

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	ENTERAL EQUIPMENT	DIRECT ALLOCATION						212	1
2	10	ENTERAL EQUIPMENT	DIRECT ALLOCATION						224	2
3	1	NUTRITIONAL SUPPLEMENTS	DIRECT ALLOCATION						2,650	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 3,086	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 0	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 0	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 0	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Insurance		X	Working Capital	$145.30						1,598	6
7	CIB Bank/S.I.R. Line		X	Line of Credit				998,742			54,955	7
8												8
9	TOTAL Facility Related				$145.30		$ 0	$ 998,742			$ 56,553	9
	B. Non-Facility Related*											
10	Supplemental Schedule							0			4,321	10
11	Interest Income		X								(631)	11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 3,690	14
15	TOTALS (line 9+line14)						$ 0	$ 998,742			$ 60,243	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Allocation - S.I.R. Mgmt.	X					$	$			$ 3,080	1
2	Allocation - Preferred Bkkpg	X									1,224	2
3	Allocation - ECMOC	X									17	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 4,321	21

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	106,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	107,019	2
3. Under or (over) accrual (line 2 minus line 1).	$	519	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	105,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	106,119	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	93,000	8
	1996	100,425	9
	1997	102,255	10
	1998	103,278	11
	1999	102,486	12

2000 accrual = 1999 tax 102,486 * 1.03 = $105,600

Line 2 includes S.I.R. Management allocation of $2,949 and Preferred Bookkeeping allocation of $1,584

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,808 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$ 0	3

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1992	55,434	1,758	20	2,772	1,014	23,773	9
10	Various			1993	68,424	1,860	20	3,421	1,561	25,189	10
11	Various			1994	44,837	766	20	2,242	1,476	15,366	11
12	Various			1995	14,482	0	20	724	724	3,677	12
13	WATER HTR WORK			1996	837	0	20	42	42	200	13
14	HOT WATER PIPING			1996	630	0	20	32	32	139	14
15	HOT WATER LINES			1996	777	0	20	39	39	182	15
16	WALK-IN COOLER			1996	3,700	95	20	185	90	848	16
17	DOORS & FRAMES			1996	683	0	20	34	34	147	17
18	DOOR ACCESS SYSTEM			1996	845	0	20	42	42	175	18
19	BLIND			1997	1,795	0	20	90	90	345	19
20	HEATER EXCHANGER			1997	4,498	518	20	225	(293)	694	20
21	REMODEL 2ND FLOOR			1997	14,985	384	20	749	365	2,871	21
22	CARPETING			1997	2,875	0	20	144	144	552	22
23	ELECTRIC STEAM TABLE			1997	1,149	0	20	57	57	223	23
24	PAGE 12-2 REP TOTALS				50,908	2,175		1,649	(526)	10,099	24
25	PAGE 12-1 REP TOTALS				33,352	1,305		1,636	331	8,313	25
26					0	0		0	0	0	26
27					0	0		0	0	0	27
28					0	0		0	0	0	28
29					0	0		0	0	0	29
30					0	0		0	0	0	30
31					0	0		0	0	0	31
32					0	0		0	0	0	32
33					0	0		0	0	0	33
34					0	0		0	0	0	34
35	PAGE 12A TOTALS				179,277	3,611		7,920	4,309	25,482	35
36	TOTAL (lines 4 thru 35)				$ 479,488	$ 12,472		$ 22,003	$ 9,531	$ 118,275	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ENTRY DOOR			1997	1,025	0	20	51	51	179	9
10	BLINDS			1997	1,684	0	20	84	84	329	10
11	PAINTING			1997	45,153	0	20	2,258	2,258	8,091	11
12	EVAPORATOR			1998	1,680	0	20	84	84	84	12
13	ELECTRICAL WORK			1998	5,825	149	20	291	142	752	13
14	MINI BLINDS			1998	769	0	20	38	38	38	14
15	SMOKE DETECTORS			1998	3,145	0	20	157	157	445	15
16	MINI BLINDS			1998	7,568	0	20	378	378	378	16
17	ELEVATOR WORK			1999	4,002	0	20	200	200	283	17
18	HVAC-HEAT EXCHANGES			1999	4,000	0	20	200	200	400	18
19	ELEVATOR REPAIR			1999	8,463	217	20	423	206	811	19
20	HVAC EXCHANGER			1999	3,875	0	20	194	194	226	20
21	WATER HEATER			1999	8,709	0	20	435	435	653	21
22	HVAC EXCHANGER			1999	3,731	0	20	187	187	218	22
23	COUNTER TOPS			1999	4,880	937	20	488	(449)	1,423	23
24	ROOM DIVIDERS			1999	6,841	0	20	342	342	399	24
25	ELEVATOR WORK			1999	2,962	0	20	148	148	197	25
26	SIR REMODELING			1999	11,917	306	20	596	290	745	26
27	WATER SOFTNER			1999	2,000	219	20	200	(19)	817	27
28	HVAC-HEAT EXCHANGER			1999	4,100	0	20	205	205	342	28
29	PAINTING			2000	16,100	120	20	268	148	268	29
30	WINDOW TREATMENT			2000	2,904	0	20	97	97	97	30
31	HEAT EXCHANGER			2000	3,940	0	20	16	16	16	31
32	PAINTING			2000	10,000	11	20	42	31	42	32
33	HEAT EXCHANGER			2000	1,145	0	20	52	52	52	33
34	WATER HEATER			2000	4,598	0	20	211	211	211	34
35	HANDRAILS			2000	8,261	1,652	20	275	(1,377)	7,986	35
36	TOTAL (lines 4 thru 35)				$ 179,277	$ 3,611		$ 7,920	$ 4,309	$ 25,482	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	0			0	0	0	0	0	0	0	9
10	0			0	0	0	0	0	0	0	10
11	0			0	0	0	0	0	0	0	11
12	0			0	0	0	0	0	0	0	12
13	0			0	0	0	0	0	0	0	13
14	0			0	0	0	0	0	0	0	14
15	0			0	0	0	0	0	0	0	15
16	0			0	0	0	0	0	0	0	16
17	0			0	0	0	0	0	0	0	17
18	0			0	0	0	0	0	0	0	18
19	0			0	0	0	0	0	0	0	19
20	0			0	0	0	0	0	0	0	20
21	0			0	0	0	0	0	0	0	21
22	0			0	0	0	0	0	0	0	22
23	0			0	0	0	0	0	0	0	23
24	0			0	0	0	0	0	0	0	24
25	0			0	0	0	0	0	0	0	25
26	0			0	0	0	0	0	0	0	26
27	0			0	0	0	0	0	0	0	27
28	0			0	0	0	0	0	0	0	28
29	0			0	0	0	0	0	0	0	29
30	0			0	0	0	0	0	0	0	30
31	0			0	0	0	0	0	0	0	31
32	0			0	0	0	0	0	0	0	32
33	0			0	0	0	0	0	0	0	33
34	0			0	0	0	0	0	0	0	34
35	0			0	0	0	0	0	0	0	35
36	TOTAL (lines 4 thru 35)				$ 0	$ 0		$ 0	$ 0	$ 0	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	0			0	0	0	0	0	0	0	9
10	0			0	0	0	0	0	0	0	10
11	0			0	0	0	0	0	0	0	11
12	0			0	0	0	0	0	0	0	12
13	0			0	0	0	0	0	0	0	13
14	0			0	0	0	0	0	0	0	14
15	0			0	0	0	0	0	0	0	15
16	0			0	0	0	0	0	0	0	16
17	0			0	0	0	0	0	0	0	17
18	0			0	0	0	0	0	0	0	18
19	0			0	0	0	0	0	0	0	19
20	0			0	0	0	0	0	0	0	20
21	0			0	0	0	0	0	0	0	21
22	0			0	0	0	0	0	0	0	22
23	0			0	0	0	0	0	0	0	23
24	0			0	0	0	0	0	0	0	24
25	0			0	0	0	0	0	0	0	25
26	0			0	0	0	0	0	0	0	26
27	0			0	0	0	0	0	0	0	27
28	0			0	0	0	0	0	0	0	28
29	0			0	0	0	0	0	0	0	29
30	0			0	0	0	0	0	0	0	30
31	0			0	0	0	0	0	0	0	31
32	0			0	0	0	0	0	0	0	32
33	0			0	0	0	0	0	0	0	33
34	0			0	0	0	0	0	0	0	34
35	0			0	0	0	0	0	0	0	35
36	TOTAL (lines 4 thru 35)				$ 0	$ 0		$ 0	$ 0	$ 0	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	0			0	0	0	0	0	0	0	9
10	0			0	0	0	0	0	0	0	10
11	0			0	0	0	0	0	0	0	11
12	0			0	0	0	0	0	0	0	12
13	0			0	0	0	0	0	0	0	13
14	0			0	0	0	0	0	0	0	14
15	0			0	0	0	0	0	0	0	15
16	0			0	0	0	0	0	0	0	16
17	0			0	0	0	0	0	0	0	17
18	0			0	0	0	0	0	0	0	18
19	0			0	0	0	0	0	0	0	19
20	0			0	0	0	0	0	0	0	20
21	0			0	0	0	0	0	0	0	21
22	0			0	0	0	0	0	0	0	22
23	0			0	0	0	0	0	0	0	23
24	0			0	0	0	0	0	0	0	24
25	0			0	0	0	0	0	0	0	25
26	0			0	0	0	0	0	0	0	26
27	0			0	0	0	0	0	0	0	27
28	0			0	0	0	0	0	0	0	28
29	0			0	0	0	0	0	0	0	29
30	0			0	0	0	0	0	0	0	30
31	0			0	0	0	0	0	0	0	31
32	0			0	0	0	0	0	0	0	32
33	0			0	0	0	0	0	0	0	33
34	0			0	0	0	0	0	0	0	34
35	0			0	0	0	0	0	0	0	35
36	TOTAL (lines 4 thru 35)				$ 0	$ 0		$ 0	$ 0	$ 0	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	0			0	0	0	0	0	0	0	9
10	0			0	0	0	0	0	0	0	10
11	0			0	0	0	0	0	0	0	11
12	0			0	0	0	0	0	0	0	12
13	0			0	0	0	0	0	0	0	13
14	0			0	0	0	0	0	0	0	14
15	0			0	0	0	0	0	0	0	15
16	0			0	0	0	0	0	0	0	16
17	0			0	0	0	0	0	0	0	17
18	0			0	0	0	0	0	0	0	18
19	0			0	0	0	0	0	0	0	19
20	0			0	0	0	0	0	0	0	20
21	0			0	0	0	0	0	0	0	21
22	0			0	0	0	0	0	0	0	22
23	0			0	0	0	0	0	0	0	23
24	0			0	0	0	0	0	0	0	24
25	0			0	0	0	0	0	0	0	25
26	0			0	0	0	0	0	0	0	26
27	0			0	0	0	0	0	0	0	27
28	0			0	0	0	0	0	0	0	28
29	0			0	0	0	0	0	0	0	29
30	0			0	0	0	0	0	0	0	30
31	0			0	0	0	0	0	0	0	31
32	0			0	0	0	0	0	0	0	32
33	0			0	0	0	0	0	0	0	33
34	0			0	0	0	0	0	0	0	34
35	0			0	0	0	0	0	0	0	35
36	TOTAL (lines 4 thru 35)				$ 0	$ 0		$ 0	$ 0	$ 0	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	0			0	0	0	0	0	0	0	9
10	0			0	0	0	0	0	0	0	10
11	0			0	0	0	0	0	0	0	11
12	0			0	0	0	0	0	0	0	12
13	0			0	0	0	0	0	0	0	13
14	0			0	0	0	0	0	0	0	14
15	0			0	0	0	0	0	0	0	15
16	0			0	0	0	0	0	0	0	16
17	0			0	0	0	0	0	0	0	17
18	0			0	0	0	0	0	0	0	18
19	0			0	0	0	0	0	0	0	19
20	0			0	0	0	0	0	0	0	20
21	0			0	0	0	0	0	0	0	21
22	0			0	0	0	0	0	0	0	22
23	0			0	0	0	0	0	0	0	23
24	0			0	0	0	0	0	0	0	24
25	0			0	0	0	0	0	0	0	25
26	0			0	0	0	0	0	0	0	26
27	0			0	0	0	0	0	0	0	27
28	0			0	0	0	0	0	0	0	28
29	0			0	0	0	0	0	0	0	29
30	0			0	0	0	0	0	0	0	30
31	0			0	0	0	0	0	0	0	31
32	0			0	0	0	0	0	0	0	32
33	0			0	0	0	0	0	0	0	33
34	0			0	0	0	0	0	0	0	34
35	0			0	0	0	0	0	0	0	35
36	TOTAL (lines 4 thru 35)				$ 0	$ 0		$ 0	$ 0	$ 0	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	0			0	0	0	0	0	0	0	9
10	0			0	0	0	0	0	0	0	10
11	0			0	0	0	0	0	0	0	11
12	0			0	0	0	0	0	0	0	12
13	0			0	0	0	0	0	0	0	13
14	0			0	0	0	0	0	0	0	14
15	0			0	0	0	0	0	0	0	15
16	0			0	0	0	0	0	0	0	16
17	0			0	0	0	0	0	0	0	17
18	0			0	0	0	0	0	0	0	18
19	0			0	0	0	0	0	0	0	19
20	0			0	0	0	0	0	0	0	20
21	0			0	0	0	0	0	0	0	21
22	0			0	0	0	0	0	0	0	22
23	0			0	0	0	0	0	0	0	23
24	0			0	0	0	0	0	0	0	24
25	0			0	0	0	0	0	0	0	25
26	0			0	0	0	0	0	0	0	26
27	0			0	0	0	0	0	0	0	27
28	0			0	0	0	0	0	0	0	28
29	0			0	0	0	0	0	0	0	29
30	0			0	0	0	0	0	0	0	30
31	0			0	0	0	0	0	0	0	31
32	0			0	0	0	0	0	0	0	32
33	0			0	0	0	0	0	0	0	33
34	0			0	0	0	0	0	0	0	34
35	0			0	0	0	0	0	0	0	35
36	TOTAL (lines 4 thru 35)				$ 0	$ 0		$ 0	$ 0	$ 0	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	0			0	0	0	0	0	0	0	9
10	0			0	0	0	0	0	0	0	10
11	0			0	0	0	0	0	0	0	11
12	0			0	0	0	0	0	0	0	12
13	0			0	0	0	0	0	0	0	13
14	0			0	0	0	0	0	0	0	14
15	0			0	0	0	0	0	0	0	15
16	0			0	0	0	0	0	0	0	16
17	0			0	0	0	0	0	0	0	17
18	0			0	0	0	0	0	0	0	18
19	0			0	0	0	0	0	0	0	19
20	0			0	0	0	0	0	0	0	20
21	0			0	0	0	0	0	0	0	21
22	0			0	0	0	0	0	0	0	22
23	0			0	0	0	0	0	0	0	23
24	0			0	0	0	0	0	0	0	24
25	0			0	0	0	0	0	0	0	25
26	0			0	0	0	0	0	0	0	26
27	0			0	0	0	0	0	0	0	27
28	0			0	0	0	0	0	0	0	28
29	0			0	0	0	0	0	0	0	29
30	0			0	0	0	0	0	0	0	30
31	0			0	0	0	0	0	0	0	31
32	0			0	0	0	0	0	0	0	32
33	0			0	0	0	0	0	0	0	33
34	0			0	0	0	0	0	0	0	34
35	0			0	0	0	0	0	0	0	35
36	TOTAL (lines 4 thru 35)				$ 0	$ 0		$ 0	$ 0	$ 0	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	0			0	0	0	0	0	0	0	9
10	0			0	0	0	0	0	0	0	10
11	0			0	0	0	0	0	0	0	11
12	0			0	0	0	0	0	0	0	12
13	0			0	0	0	0	0	0	0	13
14	0			0	0	0	0	0	0	0	14
15	0			0	0	0	0	0	0	0	15
16	0			0	0	0	0	0	0	0	16
17	0			0	0	0	0	0	0	0	17
18	0			0	0	0	0	0	0	0	18
19	0			0	0	0	0	0	0	0	19
20	0			0	0	0	0	0	0	0	20
21	0			0	0	0	0	0	0	0	21
22	0			0	0	0	0	0	0	0	22
23	0			0	0	0	0	0	0	0	23
24	0			0	0	0	0	0	0	0	24
25	0			0	0	0	0	0	0	0	25
26	0			0	0	0	0	0	0	0	26
27	0			0	0	0	0	0	0	0	27
28	0			0	0	0	0	0	0	0	28
29	0			0	0	0	0	0	0	0	29
30	0			0	0	0	0	0	0	0	30
31	0			0	0	0	0	0	0	0	31
32	0			0	0	0	0	0	0	0	32
33	0			0	0	0	0	0	0	0	33
34	0			0	0	0	0	0	0	0	34
35	0			0	0	0	0	0	0	0	35
36	TOTAL (lines 4 thru 35)				$ 0	$ 0		$ 0	$ 0	$ 0	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	0			0	0	0	0	0	0	0	9
10	0			0	0	0	0	0	0	0	10
11	0			0	0	0	0	0	0	0	11
12	0			0	0	0	0	0	0	0	12
13	0			0	0	0	0	0	0	0	13
14	0			0	0	0	0	0	0	0	14
15	0			0	0	0	0	0	0	0	15
16	0			0	0	0	0	0	0	0	16
17	0			0	0	0	0	0	0	0	17
18	0			0	0	0	0	0	0	0	18
19	0			0	0	0	0	0	0	0	19
20	0			0	0	0	0	0	0	0	20
21	0			0	0	0	0	0	0	0	21
22	0			0	0	0	0	0	0	0	22
23	0			0	0	0	0	0	0	0	23
24	0			0	0	0	0	0	0	0	24
25	0			0	0	0	0	0	0	0	25
26	0			0	0	0	0	0	0	0	26
27	0			0	0	0	0	0	0	0	27
28	0			0	0	0	0	0	0	0	28
29	0			0	0	0	0	0	0	0	29
30	0			0	0	0	0	0	0	0	30
31	0			0	0	0	0	0	0	0	31
32	0			0	0	0	0	0	0	0	32
33	0			0	0	0	0	0	0	0	33
34	0			0	0	0	0	0	0	0	34
35	0			0	0	0	0	0	0	0	35
36	TOTAL (lines 4 thru 35)				$ 0	$ 0		$ 0	$ 0	$ 0	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PREFERRED BOOKKEEPING ALLOCATION			1997	18,261	688	20	913	225	3,478	9
10	PREFERRED BOOKKEEPING ALLOCATION			1999	145	46	20	7	(39)	11	10
11	PREFERRED BOOKKEEPING ALLOCATION			2000	916	0	20	19	19	19	11
12											12
13											13
14	S.I.R. MANAGEMENT ALLOCATION			1993	11,690	388	20	590	202	4,607	14
15	S.I.R. MANAGEMENT ALLOCATION			1994	36	0	20	4	4	23	15
16	S.I.R. MANAGEMENT ALLOCATION			1995	267	15	20	13	(2)	72	16
17	S.I.R. MANAGEMENT ALLOCATION			1999	1,270	84	20	64	(20)	77	17
18	S.I.R. MANAGEMENT ALLOCATION			2000	767	84	20	26	(58)	26	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 33,352	$ 1,305		$ 1,636	$ 331	$ 8,313	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	213			1993	$ 27,217	$ 864	35	$ 778	$ (86)	$ 5,832	4
5				1993	14,622	464	35	418	(46)	3,133	5
6											6
7											7
8											8
	Improvement Type**										
9	S.I.R. Properties - S.I.R. Management Allocation			1993	441	23	20	22	(1)	166	9
10	S.I.R. Properties - S.I.R. Management Allocation			1994	259	7	20	13	6	84	10
11	S.I.R. Properties - S.I.R. Management Allocation			1997	103	10	20	5	(5)	23	11
12	S.I.R. Properties - S.I.R. Management Allocation			1998	1,648	165	20	82	(83)	206	12
13	S.I.R. Properties - S.I.R. Management Allocation			1999	3,449	345	20	172	(173)	259	13
14											14
15											15
16	S.I.R. Properties - Preferred Bookkeeping Allocation			1993	237	13	20	12	(1)	89	16
17	S.I.R. Properties - Preferred Bookkeeping Allocation			1994	139	4	20	7	3	45	17
18	S.I.R. Properties - Preferred Bookkeeping Allocation			1997	55	6	20	3	(3)	12	18
19	S.I.R. Properties - Preferred Bookkeeping Allocation			1998	885	89	20	44	(45)	111	19
20	S.I.R. Properties - Preferred Bookkeeping Allocation			1999	1,853	185	20	93	(92)	139	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 50,908	$ 2,175		$ 1,649	$ (526)	$ 10,099	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 373,573	$ 30,944	$ 36,471	$ 5,527		$ 203,518	37
38	Current Year Purchases	38,898	7,749	2,812	(4,937)		2,812	38
39	Fully Depreciated Assets	0	15,715	0	(15,715)		0	39
40					0			40
41	TOTALS	$ 412,471	$ 54,408	$ 39,283	$ (15,125)		$ 206,330	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY BUSINESS	1977 CHEVROLET VAN	1996	$ 11,516	$ 1,309	$ 0	$ (1,309)	5	$ 11,516	42
43							0			43
44							0			44
45							0			45
46	TOTALS			$ 11,516	$ 1,309	$ 0	$ (1,309)		$ 11,516	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 903,475	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 68,189	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 61,286	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (6,903)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 336,121	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

FAIRVIEW NURSING PLAZA, INC.
0037655
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
FAIRVIEW NURSING PLAZA	313,772	26,422	30,644	4,222	165,818
PREFERRED BOOKKEEPING	21,213	1,519	1,968	449	13,011
S.I.R. MANAGEMENT	38,549	3,003	3,855	852	24,660
S.I.R. PROPERTIES - S.I.R. MANAGEMENT	25		3	3	19
S.I.R. PROPERTIES - PREFERRED BOOKKEEPING	14		1	1	10
TOTALS	373,573	30,944	36,471	5,527	203,518
LINE 29: CURRENT YEAR					
FAIRVIEW NURSING PLAZA	37,071	7,414	2,701	(4,713)	2,701
PREFERRED BOOKKEEPING	618	124	52	(72)	52
S.I.R. MANAGEMENT	1,209	211	59	(152)	59
S.I.R. PROPERTIES - S.I.R. MANAGEMENT					
S.I.R. PROPERTIES - PREFERRED BOOKKEEPING					
TOTALS	38,898	7,749	2,812	(4,937)	2,812
LINE 30: FULLY DEPRECIATED					
FAIRVIEW NURSING PLAZA		15,715		(15,715)	
PREFERRED BOOKKEEPING					
S.I.R. MANAGEMENT					
S.I.R. PROPERTIES - S.I.R. MANAGEMENT					
S.I.R. PROPERTIES - PREFERRED BOOKKEEPING					
TOTALS		15,715		(15,715)	
TOTALS (Should Tie to Totals on Page 13)					
FAIRVIEW NURSING PLAZA	350,843	49,551	33,345	(16,206)	168,519
PREFERRED BOOKKEEPING	21,831	1,643	2,020	377	13,063
S.I.R. MANAGEMENT	39,758	3,214	3,914	700	24,719
S.I.R. PROPERTIES - S.I.R. MANAGEMENT	25		3	3	19
S.I.R. PROPERTIES - PREFERRED BOOKKEEPING	14		1	1	10
TOTALS	412,471	54,408	39,283	(15,125)	206,330

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: FIRST CHICAGO TRUST COMPANY OF ILLINOIS

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		213		$ 942,238			3
4	Additions							4
5								5
6								6
7	TOTAL		213		$ 942,238 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 02/1996
Ending 09/2011

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 18,764 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$ 0	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 2,655	$		$ 2,655	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			610			610	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			11,945			11,945	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				21,400		21,400	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**						17,885		17,885	13
14	TOTAL			$		$ 15,210	$ 39,285		$ 54,495	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Specialty Beds	12,763
2	Enteral Supplies	2,690
3	Equipment Rental	2,432
4		
5		
6		
7		
8		
9		
10		
		17,885

	Outside Therapies (Column 5 - Other)	Amount
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 106,444	$ 0	1
2	Cash-Patient Deposits	48,674	0	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	746,696	0	3
4	Supply Inventory (priced at)	0	0	4
5	Short-Term Investments	0	0	5
6	Prepaid Insurance	4,622	0	6
7	Other Prepaid Expenses	675	0	7
8	Accounts Receivable (owners or related parties)	21,400	0	8
9	Other(specify): See supplemental schedule	76,105	0	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,004,616	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0	0	11
12	Long-Term Investments	0	0	12
13	Land	0	0	13
14	Buildings, at Historical Cost	0	0	14
15	Leasehold Improvements, at Historical Cos	223,809	0	15
16	Equipment, at Historical Cost	446,443	0	16
17	Accumulated Depreciation (book methods)	(382,310)	0	17
18	Deferred Charges	0	0	18
19	Organization & Pre-Operating Costs	0	0	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	0	0	20
21	Restricted Funds	0	0	21
22	Other Long-Term Assets (specify):	0	0	22
23	Other(specify): See supplemental schedule	0	0	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 287,942	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,292,558	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 212,980	$ 0	26
27	Officer's Accounts Payable	0	0	27
28	Accounts Payable-Patient Deposits	50,558	0	28
29	Short-Term Notes Payable	998,742	0	29
30	Accrued Salaries Payable	185,504	0	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,218	0	31
32	Accrued Real Estate Taxes(Sch.IX-B)	105,600	0	32
33	Accrued Interest Payable	2,900	0	33
34	Deferred Compensation	0	0	34
35	Federal and State Income Taxes	0	0	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	1,500	0	36
37		0	0	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,572,002	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	0	0	39
40	Mortgage Payable	0	0	40
41	Bonds Payable	0	0	41
42	Deferred Compensation	0	0	42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule	0	0	43
44		0	0	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,572,002	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (279,444)	$ 0	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,292,558	$ 0	48

*(See instructions.)

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. **#** 0037655 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	76,105	
	76,105	

OTHER NON CURRENT ASSETS:

OTHER CURRENT LIABILITIES:	Amount	Amount
Deferred Replacement Tax	1,500	
	1,500	

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 243,817	1
2	Restatements (describe):		2
3	Schedule attached	0	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 243,817	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(553,261)	7
8	Aquisitions of Pooled Companies	0	8
9	Proceeds from Sale of Stock	30,000	9
10	Stock Options Exercised	0	10
11	Contributions and Grants	0	11
12	Expenditures for Specific Purposes	0	12
13	Dividends Paid or Other Distributions to Owners	(0)	13
14	Donated Property, Plant, and Equipment	0	14
15	Other (describe)	0	15
16	Other (describe)	0	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (523,261)	17
	B. Transfers (Itemize):		
18		0	18
19		0	19
20		0	20
21		0	21
22		0	22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (279,444)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	FAIRVIEW NURSING PLAZA, INC. # 0037655	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		243,817
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		243,817
Equity(Deficit) from Page 17 Col 1		(279,444)
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		(279,444)

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,230,164	1
2	Discounts and Allowances for all Levels	(51,059)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,179,105	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients	0	5
6	Therapy	0	6
7	Oxygen	0	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education	0	9
10	Other Government Grants	0	10
11	Nurses Aide Training Reimbursements	0	11
12	Gift and Coffee Shop	0	12
13	Barber and Beauty Care	0	13
14	Non-Patient Meals	0	14
15	Telephone, Television and Radio	0	15
16	Rental of Facility Space	0	16
17	Sale of Drugs	0	17
18	Sale of Supplies to Non-Patients	0	18
19	Laboratory	0	19
20	Radiology and X-Ray	0	20
21	Other Medical Services	59,027	21
22	Laundry	23,870	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 82,897	23
	D. Non-Operating Revenue		
24	Contributions	0	24
25	Interest and Other Investment Income***	631	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 631	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	0	27
28	See supplemental schedule	2,432	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,432	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,265,065	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,066,160	31
32	Health Care	2,455,061	32
33	General Administration	955,683	33
	B. Capital Expense		
34	Ownership	1,169,989	34
	C. Ancillary Expense		
35	Special Cost Centers	54,495	35
36	Provider Participation Fee	116,938	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,818,326	40
41	**Income before Income Taxes (line 30 minus line 40)****	(553,261)	41
42	**Income Taxes**	0	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (553,261)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FAIRVIEW NURSING PLAZA, IN(# 0037655 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	786
2	State Replacement Tax	1,646
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	2,432

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,991	2,069	$ 63,700	$ 30.79	1
2	Assistant Director of Nursing	1,549	1,629	35,513	21.80	2
3	Registered Nurses	4,249	4,609	86,468	18.76	3
4	Licensed Practical Nurses	28,866	30,929	524,146	16.95	4
5	Nurse Aides & Orderlies	60,878	64,117	562,533	8.77	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,349	3,940	37,438	9.50	8
9	Activity Director	1,669	1,861	21,789	11.71	9
10	Activity Assistants	9,760	10,170	69,181	6.80	10
11	Social Service Workers	9,970	10,455	145,562	13.92	11
12	Dietician					12
13	Food Service Supervisor	1,907	2,021	27,119	13.42	13
14	Head Cook	2,438	2,553	18,544	7.26	14
15	Cook Helpers/Assistants	20,121	20,700	133,611	6.45	15
16	Dishwashers					16
17	Maintenance Workers	3,413	3,660	43,275	11.82	17
18	Housekeepers	24,353	25,188	178,209	7.08	18
19	Laundry	9,195	9,669	73,403	7.59	19
20	Administrator	1,937	2,027	81,779	40.34	20
21	Assistant Administrator	1,921	2,091	49,521	23.68	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,849	6,327	80,571	12.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,344	6,691	88,644	13.25	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	199,759	210,706	$ 2,321,006 *	$ 11.02	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	347	$ 14,058	1-3	35
36	Medical Director	Monthly	7,200	9-3	36
37	Medical Records Consultant	56	1,960	10-3	37
38	Nurse Consultant	Monthly	42,180	10-3	38
39	Pharmacist Consultant	45	892	10-3	39
40	Physical Therapy Consultant	120	5,993	10a-3	40
41	Occupational Therapy Consultant	33	1,650	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	365	10a-3	43
44	Activity Consultant	49	2,174	11-3	44
45	Social Service Consultant	76	4,002	12-3	45
46	Other(specify) Psych-Social Consult				46
47	Psych-Social Consultant	16	736	12-3	47
48	Director of Food Service	543	21,732	1-3	48
49	TOTAL (lines 35 - 48)	1,292	$ 102,942		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,320	$ 67,688	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides	31,099	565,478	10-3	52
53	TOTAL (lines 50 - 52)	33,419	$ 633,166		53

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Solomon 1/1-12/31/2000	Administrator	6.58%	$ 81,779
Lori Fernandez 1/1-12/31/2000	Asst. Administrator	0	49,521
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 131,300

B. Administrative - Other

Description	Amount
Director of Admin Services - S.I.R. Management	$ 26,844
Ancillary Administrator - S.I.R. Management	47,892
Management Fees	
Allocation ECM Owners Council Dues	4,320
TOTAL (agree to Schedule V, line 17, col. 3)	$ 79,056
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Attorney Fees (See Attached)	Legal Services	$ 30,847
Preferred Bookkeeping	Accounting Services	19,400
Frost, Ruttenberg & Rothblatt	Accounting Services	19,555
Preferred Bookkeeping	MIS Consultants	5,112
Personnel Planners	Unemployment Consultants	1,487
Preferred Bookkeeping	Bookkeeping Services	71,568
Sinclair Kossoff	Union Arbitration	907
ICS Solutions	Software Maintenance	175
Mid-America Programming Svc.	Software Maintenance	1,320
S.I.R. Management	Regulatory Consulting	17,256
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 167,627

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,032
Unemployment Compensation Insurance	28,625
FICA Taxes	177,563
Employee Health Insurance	31,978
Employee Meals	16,653
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	1,461
401K Contribution	3,210
Employee Physicals	8,088
TOTAL (agree to Schedule V, line 22, col.8)	$ 274,610

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	22,569
Health Care Worker Background Check	1,210
(Indicate # of checks performed 121)	
Dues & Subscriptions & Fees	6,724
Advertising & Promotion	3,993
Yellow Pages Advertising	251
Allocation - ECMOC	12
Allocation - S.I.R. Management	1,045
Allocation - Preferred Bookkeeping	379
Less: Public Relations Expense	( )
Non-allowable advertising	(3,993)
Yellow page advertising	(251)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,139

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,439
Allocation - Preferred Bookkeeping	192
Allocation - S.I.R. Management	566
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,197

**See instructions.

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number FAIRVIEW NURSING PLAZA, INC. # 0037655 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC - $6,041**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,800** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **116,937**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **X** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **16,653** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%In14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw